CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 495

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: MARCH 4, 2005

Change Request 3752

SUBJECT: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)--Further Clarifications

I. SUMMARY OF CHANGES: This CR seeks to clarify some aspects of IPF PPS based on questions during the IPF Train-the-Trainer session with FIs.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 1, 2005

IMPLEMENTATION DATE : April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – ***Only One Per Row.***

R/N/D	Chapter / Section / SubSection / Title
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 495	Date: March 4, 2005	Change Request 3752

SUBJECT: Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) –Further Clarifications

I. GENERAL INFORMATION

A. Background: This transmittal further clarifies some aspects of IPF PPS. This transmittal does not replace Change Request (CR) 3541 or 3678, but will clarify recent questions CMS has received from IPFs and the Medicare fiscal intermediaries (FIs) that service them. It also corrects some aspects of 3678. See CR 3541 for an overview of all of the policy and billing requirements related to IPF PPS. Also see the November 15, 2004 final rule (69 FR 66922). Be advised that a Correction Notice to the Final Rule is also expected.

B. Policy: The following sections below are <u>all</u> corrections to CR 3678:

- Blood-clotting factors are <u>not</u> considered a pass-through cost paid outside the IPF PPS. Payment for the factors is made through the Coagulation Factor Deficits comorbidity adjustment.
- Nursing and allied health education costs are pass-through costs paid outside the IPF PPS. Information regarding nursing and allied health will be placed in the IPF PPS correction notice.
- For PIP providers, ECT and Outlier payments are not included in the PIP payment amount, but are paid on the discharge claim for ECT and on a discharge, benefits exhaust, or last day of a Medicare covered level of care claim, for outlier.

<u>New IPF Provider</u>

We defined a new IPF as a provider of inpatient hospital psychiatric services that otherwise meets the qualifying criteria for IPFs, set forth in 42 CFR §412.22, §412.23, §412.25, and §412.27, which under current ownership, previous ownership, or both, that has not received payment under TEFRA for delivery of IPF services prior to the effective date of the IPF PPS, January 1, 2005. To qualify, the first cost report period as a psychiatric hospital or a distinct part unit in an acute care hospital must have begun no earlier than January 1, 2005, coinciding with the effective date of the IPF PPS.

This means if the provider ever had a TEFRA limit, we will go back and use that TEFRA limit updated to current times. The IPF will not be a new provider and therefore will receive the blended payment. This includes those providers that previously closed their psych units and then re-opened the psych units; if they had a TEFRA limit established, we will update that TEFRA limit.

Change of ownership (CHOW) will have no impact on whether an IPF is considered a new IPF provider.

CODE FIRST EXAMPLE

Diagnosis code 294.11 “Dementia in Conditions Classified Elsewhere with Behavioral disturbances” is designated as “NOT ALLOWED AS PRINCIPAL DX” code.

Four digit code 294.1 “Dementia in Conditions Classified Elsewhere”, is designated as a “Code first” diagnosis indicating that all 5 digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the “code first” rule. The 3 digit code 294 “Persistent Mental Disorders Due to Conditions Classified Elsewhere” appears in the ICD-9-CM as follows:

294 PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE

294.1 Dementia in Conditions Classified Elsewhere

Code first any underlying physical condition, as:
Dementia in:

- Alzheimer’s disease (331.0)
- Cerebral lipidosis (330.1)
- Dementia with Lewy bodies (331.82)
- Dementia with Parkinsonism (331.81)
- Epilepsy (345.0 – 345.9)
- Frontal dementia (331.19)
- Frontotemporal dementia (331.19)
- General paresis [syphilis] (094.1)
- Hepatolenticular degeneration (275.1)
- Huntington’s chorea (333.4)
- Jacob-Creutzfeldt disease (046.1)
- Multiple sclerosis (340)
- Pick's disease of the brain (331.11)
- Polyarteritis nodosa (446.0)
- Syphilis (094.1)

294.10 Dementia in Conditions Classified Elsewhere without Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

294.11 dementia in Conditions Classified Elsewhere With Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

According to "code first" requirements, the provider would code the appropriate physical condition first, for example note, 333.4 “Huntington’s Chorea” as the primary diagnosis code and 294.11 “Dementia In Conditions Classified Elsewhere With Behavioral Disturbances” as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding for a true Code First situation. However, in this case, the principal diagnosis groups to one of the 15 DRGs for which we pay an adjustment. Had the

diagnosis code grouped to a non-psychiatric DRG, the Pricer would search the secondary diagnosis codes for a psychiatric code listed in the "Code First" list to assign a DRG adjustment.

Comorbidity Chart (page 7 of CR 3541) is corrected as follows:

Oncology Treatment	1400-2399 WITH a radiation therapy (92.21-92.29)OR chemotherapy code (99.25)
Chronic Obstructive Pulmonary Disease	V4611, V4612, 49121, 4941,5100, 51883, and 51884
Renal Failure, Acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731,63732,6383, 6393, 66932, 66934, and 9585.
Drug and/or Alcohol Induced Mental Disorders	2910, 2920, 29212, 2922, 30300, and 30400

Split Billing/Stays Prior to and Discharges After IPF PPS Implementation Date

CMS apologizes for all of the confusion surrounding how IPFs are supposed to bill for patients in-house when the facility's cost report begin date triggers the transition to IPF PPS. In CR 3678, we stated that IPFs had to split bill. During our training session with Fiscal Intermediaries, it was determined that providers did not have to split bill and that FIs could override reason code 32061.

Therefore, for IPFs that have already split their bill because you received reason code 32061 and/or because you followed the instructions in CR 3678, you must cancel your pre-transition bill and rebill your claim, showing all services from the admission date through discharge, as described in CR 3541. You must do this by April 1, 2005, so that mass adjustments can be appropriately applied. Your FI will be instructed to override the reason code, 32061, that forces you to split the bill.

If you have not split your bill, continue to follow the instructions in CR 3541. Your FI will override reason code 32061.

To summarize, IPFs should follow the instructions in CR 3541 (split billing not allowed) and ignore the instruction in CR 3678 regarding this issue.

Keep in mind that if your patient did not have Medicare benefits, exhausted his/her benefits, or is in a non-covered level of care at transition, you may continue to submit no-pay bills every 30 days.

Date to Notify FIs of Emergency Department

Some FIs have requested an extension for their IPFs to notify them of their emergency room status. IPFs with cost reporting periods beginning between January 1, 2005 and March 1, 2005 shall notify their FI by March 7, 2005.

CMS will allow FIs the discretion of how they wish to be notified and what type of documentation they will require.

Fields 21 and 23 of IPF Provider Specific File (This section particularly pertains to FIs only)

Field 21 is defined as the "Case Mix Adjusted Cost per Discharge/PPS Facility Rate". This field shall be populated with the IPFs cost per discharge amount. FIs shall review cost per discharge amounts periodically and adjust as appropriate.

Filed 23 is defined as the "Intern to Bed Ratio". The IPF Pricer is using this field to make the teaching adjustment. FIs shall populate this field with the ratio of interns and residents to the average daily census (ADC).

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3752.1	FIs shall override reason code 32061 for IPFs that have patients in-house over their transition to PPS.	X								
3752.2	FIs shall populate field 23 of the provider specific file with the ratio of interns and residents to the average daily census.	X								
3752.3	FIs shall accept IPF notifications of emergency departments for January 1, 2005 – March 1, 2005 IPFs until March 7, 2005. (For all other cost report begin dates, IPFs shall notify their FI 30 days prior.)	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3752.1 and 3752.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Cost reporting periods beginning on or after January 1, 2005. **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Policy: Dorothy Colbert, (410) 786-9671 Claims Processing: Sarah Shirey, (410) 786-0187 **Post-Implementation Contact(s):** Appropriate CMS Regional Office	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

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